IUPUI Campus Health
HEALTH HISTORY FORM

NAME: ______________________________ **DOB:** __________ **JOB TITLE:** ________________________
(Last, First, MI) (mo/day/yr)

ADDRESS: ______________________________ **Phone – Home/Cell:** _____________________

______________________________ **Work:** _____________________

____

MEDICATIONS you are currently taking (including vitamins, herbs, birth control pills, etc):

NAME	DOSE	Date Started

ALLERGIES (including drugs, dust, pollen, grasses, eggs, feathers, foods, latex, or other?) **NONE** ______

ALLERGY	REACTION	DATE of REACTION

Please list serious illnesses, injuries, any surgeries and hospitalizations, the year and the provider at the time

Year	Illnesses, Injuries, Surgeries and Hospitalizations	Provider

FAMILY HISTORY

FATHER ___ Living __ Deceased ___Age at death

Alcoholism	___	Hypertension	___
Anxiety	___	Kidney Disease	___
Arthritis	___	Liver Disease	___
Asthma	___	Obesity	___
Cancer	___	Seizures	___
Depression	___	Stomach Trouble	___
Diabetes	___	Tuberculosis	___
Heart Disease	___	Other	________________

MOTHER ___Living __ Deceased __ Age at death

Alcoholism	___	Hypertension	___
Anxiety	___	Kidney Disease	___
Arthritis	___	Liver Disease	___
Asthma	___	Obesity	___
Cancer	___	Seizures	___
Depression	___	Stomach Trouble	___
Diabetes	___	Tuberculosis	___
Heart Disease	___	Other	____________________

Please turn over and complete the other side

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YOUR HISTORY – Please check if you have ever had any of the following:

__ Acid Reflux
__ Alcohol/Drug Dependence
__ Anemia
__ Anxiety
__ Asthma/Hay Fever
__ Bipolar Disorder
__ Bleeding Disorder
__ Blood Clots (VTE, PE)
__ Chest Pain/Pressure
__ Chicken Pox
__ Chronic Cough
__ Chronic Fatigue
__ Depression
__ Diabetes
__ Dizziness/Fainting
__ Eczema/Psoriasis
__ Epilepsy
__ Gallbladder Trouble
__ Gluten Sensitivity
__ Gum/Tooth Trouble
__ Headaches
__ Hearing/Vision Disorder
__ Heart Murmur
__ Heart Palpitations
__ Hepatitis
__ Hernia
__ Hives
__ Insomnia
__ Irregular Periods
__ Irritable Bowel Syndrome
__ Kidney Stones
__ Lactose Intolerance
__ Malaria
__ Measles
__ Mononucleosis
__ Musculoskeletal Disorder
__ Nose/Throat Trouble
__ Personality Disorder
__ Poliomyelitis
__ Pregnancy
__ Recent Weight Gain/Loss
__ Rheumatic Fever
__ Scarlet Fever
__ Seizures
__ STD
__ Shortness of Breath
__ Shoulder Dislocation
__ Sinusitis
__ Sleep Disorder
__ Thyroid Disease
__ Tuberculosis
__ Tumor/Cancer/Cyst

Other ____

Do you use tobacco products? NO YES

Type: Chew Cigarette Cigar

Do you drink alcohol? NO DAILY WEEKLY MONTHLY

Type: Beer Wine Hard liquor

Are you aware of any injury or illness that may interfere with your job or may require accommodations on your job such as:

	NO	YES	If yes, give brief explanation
Sensitivity to chemicals, dust, sunlight, etc?			
Inability to perform certain motions?			
Inability to assume certain positions?			
Other medical issue? (list below)			

I have carefully read and completed the foregoing information in this Health History Form. I certify that my answers and explanations are true to the best of my knowledge and belief.

Signature ____ **Date** ______________________